		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031674

Facility Name: HILLSBORO REHAB & HCC

Address: 1300 EAST TREMONT (Number) HILLSBORO (City) 62049 (Zip Code)

County: MONTGOMERY

Telephone Number: 217-532-6191 **Fax #** 217-532-6194

IDPA ID Number: 51-02271905

Date of Initial License for Current Owners: 12/1/1986

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ken Marx, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Junior Foster, THSCLLC, Mgt. Co for

(Title) HILLSBORO REHAB & HCC

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,286	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	121	TOTALS	121	44,286	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	Private Pay	Other	5 Total	
8	SNF	18,553	8,972	2,302	29,827	8
9	SNF/PED	0	0	0		9
10	ICF	0	0	0		10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	18,553	8,972	2,302	29,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.35%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? NO

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/18/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date ######## NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 2,302

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,976	8,453	5,718	160,147		160,147	(4,706)	155,441			1
2	Food Purchase		129,486		129,486		129,486	(485)	129,001			2
3	Housekeeping		6,972	83,176	90,148		90,148		90,148			3
4	Laundry		7,694	55,542	63,236		63,236		63,236			4
5	Heat and Other Utilities			114,901	114,901		114,901		114,901			5
6	Maintenance	23,078	14,936	31,195	69,209		69,209		69,209			6
7	Other (specify):*			3,006	3,006		3,006		3,006			7
8	**TOTAL General Services**	169,054	167,541	293,538	630,133		630,133	(5,191)	624,942			8
	B. Health Care and Programs											
9	Medical Director			12,240	12,240		12,240		12,240			9
10	Nursing and Medical Records	1,012,555	64,026	5,246	1,081,827		1,081,827		1,081,827			10
10a	Therapy			120,362	120,362		120,362		120,362			10a
11	Activities	77,411	3,143	2,764	83,318		83,318		83,318			11
12	Social Services	70,840	69	2,739	73,648		73,648		73,648			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,160,806	67,238	143,351	1,371,395		1,371,395		1,371,395			16
	C. General Administration											
17	Administrative	66,525			66,525		66,525		66,525			17
18	Directors Fees											18
19	Professional Services			243,618	243,618		243,618	1,653	245,271			19
20	Dues, Fees, Subscriptions & Promotions			32,241	32,241		32,241	(22,485)	9,756			20
21	Clerical & General Office Expenses	59,929	17,907	37,797	115,633		115,633	(25,529)	90,104			21
22	Employee Benefits & Payroll Taxes			258,081	258,081		258,081	6,765	264,846			22
23	Inservice Training & Education			1,244	1,244		1,244	847	2,091			23
24	Travel and Seminar			888	888		888	3,491	4,379			24
25	Other Admin. Staff Transportation			5,751	5,751		5,751		5,751			25
26	Insurance-Prop.Liab.Malpractice			128,665	128,665		128,665		128,665			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,454	17,907	708,285	852,646		852,646	(35,258)	817,388			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,456,314	252,686	1,145,174	2,854,174		2,854,174	(40,449)	2,813,725			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLSBORO HCC #31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			130,857	130,857		130,857	618	131,475			30
31	Amortization of Pre-Op. & Org.			14,436	14,436		14,436	(14,436)	(0)			31
32	Interest			359,172	359,172		359,172	(5,806)	353,366			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,033	2,033		2,033		2,033			35
36	Other (specify):*											36
37	**TOTAL Ownership**			506,498	506,498		506,498	(19,624)	486,874			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		88,850	46,555	135,405		135,405		135,405			39
40	Barber and Beauty Shops		729		729		729		729			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,429	66,429		66,429		66,429			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		89,579	112,984	202,563		202,563		202,563			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,456,314	342,265	1,764,656	3,563,235		3,563,236	(60,073)	3,503,162			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,706)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,806)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(26)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,425)	21		24
25	Fund Raising, Advertising and Promotional	(22,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,710)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,158)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(14,436)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	13,521	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (915)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (60,073)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HILLSBORO HCC

ID# 31674

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (3,843)	21	1
2	Raw Foods Rebate	(485)	2	2
3	Depreciation adjustment	618	30	3
4	0	0	0	4
5	0	0	0	5
6	0	0	0	6
7	0	0	0	7
8	0	0	0	8
9	0	0	0	9
10	0	0	0	10
11	0	0	0	11
12	0	0	0	12
13	0	0	0	13
14	0	0	0	14
15	0	0	0	15
16	0	0	0	16
17	0	0	0	17
18	0	0	0	18
19	0	0	0	19
20	0	0	0	20
21	0	0	0	21
22	0	0	0	22
23	0	0	0	23
24	0	0	0	24
25	0	0	0	25
26	0	0	0	26
27	0	0	0	27
28	0	0	0	28
29	0	0	0	29
30	0	0	0	30
31	0	0	0	31
32	0	0	0	32
33	0	0	0	33
34	0	0	0	34
35	0	0	0	35
36	0	0	0	36
37	0	0	0	37
38	0	0	0	38
39	0	0	0	39
40	0	0	0	40
41	0	0	0	41
42	0	0	0	42
43	0	0	0	43
44	0	0	0	44
45	0	0	0	45
46	0	0	0	46
47	0	0	0	47
48	0	0	0	48
49	**Total**	(3,710)		49

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		See Attached Listings				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Midamerica Care Foundation	100.00%	$ 0	$	1
2	V	19	Professional Services		Midamerica Care Foundation	100.00%	1,653	1,653	2
3	V	20	Due, Fees, Subscriptions & Promotions		Midamerica Care Foundation	100.00%	0		3
4	V	21	Clerical & Other General Office		Midamerica Care Foundation	100.00%	765	765	4
5	V	22	Employee Benefits		Midamerica Care Foundation	100.00%	6,765	6,765	5
6	V	24	Travel & Seminar		Midamerica Care Foundation	100.00%	847	847	6
7	V	26	Insurance		Midamerica Care Foundation	100.00%	3,491	3,491	7
8	V	0	0		0	0.00%			8
9	V	0	0		0	0.00%			9
10	V	0	0		0	0.00%			10
11	V	0	0		0	0.00%			11
12	V	0	0		0	0.00%			12
13	V	0	0		0	0.00%			13
14	Total			$			$ 13,521	$ * 13,521	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MidAmerica Care Foundation
Street Address: 7611 State Line Rd Ste 301
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816-444-0900
Fax Number: (0

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	eat and Other Utilities	Patient Days	241,015	8	0		29,827	$	1
2	19	Professional Services	Patient Days	241,015	8	13,353		29,827	0 1,653	2
3	20	, Subscriptions & Promotions	Patient Days	241,015	8	0		29,827	0	3
4	21	al & Other General Office	Patient Days	241,015	8	6,180		29,827	0 765	4
5	22	Employee Benefits	Patient Days	241,015	8	54,667		29,827	0 6,765	5
6	24	Travel & Seminar	Patient Days	241,015	8	6,843		29,827	0 847	6
7	26	Insurance	Patient Days	241,015	8	28,208		29,827	0 3,491	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,251	$		$ 13,521	25

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original		Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term												
1	Hillsboro Class 5(C) Bonds		X	Mortage	VARIES	1/1/1985	$	3,225,000	3,484,610	12/1/2015	0.135	$ 356,973	1
2	Montgomery Co. Clerk		X	Past Due R/E Taxes	Varies	4/1/1991		92,432	36,784		0.0875	2,199	2
3					Varies								3
4													4
5													5
	Working Capital												
6	Interest Income		X									(5,806)	6
7	H/O Interest Income												7
8													8
9	TOTAL Facility Related						$	3,317,432	$ 3,521,394			$ 353,366	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						$		$			$	14
15	TOTALS (line 9+line14)						$	3,317,432	$ 3,521,394			$ 353,366	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLSBORO HCC COUNTY MONTGOMERY

FACILITY IDPH LICENSE NUMBER 31674

CONTACT PERSON REGARDING THIS REPORT Ken Marx, BKD, LLP

TELEPHONE 314-231-5544 FAX #: 314-231-9731

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior BRICK & BLOCK Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 346,960
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 14,436
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	12,500		$ 11,000	1
2					2
3	TOTALS	12,500		$ 11,000	3

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		86	75	$ 1912284	$ 63,747	30	$ 63,747	$	$ 1,238,672	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements 1987			87	157,574	5,434	29	5,434		91,435	9
10	Improvements 1988			88	14,657	666	22	666		8,851	10
11	Improvements 1991			91	67,423		7			73,118	11
12	Improvements 1992			92	22,889	3,270	7	3,270		20,378	12
13	Improvements 1993			93	26,338		7			30,691	13
14	Improvements 1994			94	21,421	462	8	462		21,421	14
15	Improvements 1995			95	24,004	2,400	10	2,400		20,336	15
16	Improvements 1996			96	38,503	898	15	898		38,503	16
17	Improvements 1997			97	97,159	6,940	14	6,940		57,750	17
18	Weather Proof			98	1,825	183	10	183		1,050	18
19	Shower Repair			99	655	66	10	66		328	19
20	Heating/AC Units			99	5,084	508	10	508		2,584	20
21	Compressor for Walk In Cooler			2000	714	71	10	71		303	21
22	A/C 5 Ton			2000	3,242	648	5	648		2,647	22
23	Landscaping			2001	3,943	394	10	394		1,577	23
24	Remodel Alzheimer Wing			2001	10,747	716	15	716		2,209	24
25	Alarms Systems, Fire & Doors			2001	4,891	489	10	489		1,508	25
26	Landscaping			2002	3,514	351	10	351		878	26
27	Sign			2002	850	85	10	85		213	27
28	Merlin Control Box			2002	1,567	313	5	313		835	28
29	Wooden Doors & Metal Frames			2002	530	35	15	35		94	29
30	Doorway 6'			2002	2,070	104	20	104		268	30
31	Tile			2002	1,249	125	10	125		302	31
32	Replaced Plumbing in Restrooms			2002	2,810	141	20	141		328	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remove and Install Gutters and Downspouts	2002	$ 1,750	$ 175	10	$ 175	$	$ 394	37
38	Fixtures	2002	1,631	163	10	163		353	38
39	Roof Top A/C Heeter Unit	2002	7,982	798	10	798		1,596	39
40	Two Tube Surface Wrap Fixtures	2002	739	74	10	74		148	40
41	Reseal Blacktop	2003	3,561	445	8	445		890	41
42	Outside Light Posts	2003	6,723	448	15	448		896	42
43	Roof Top A/C Heeter	2003	7,982	798	10	798		1,596	43
44	Apply 2 Coats of	2003	12,575	1,258	10	1,258		2,516	44
45	Roof Repairs to Front	2003	1,100	110	10	110		220	45
46	Hot Water Heater	2003	6,392	639	10	639		1,278	46
47	Utility Meter	2003	1,284	64	20	64		128	47
48	Drywall Living Room	2003	3,330	167	20	167		334	48
49	Stainless Steel Three	2003	849	42	20	42		84	49
50	Vinyl clad wrap	2003	24,697	1,646	15	1,646		3,292	50
51	Paint in Dining, Living	2003	4,175	418	10	418		836	51
52	Pair of Bronze Kawneer	2003	2,324	155	15	155		310	52
53	Wallcoverings	2003	1,933	387	5	387		774	53
54	Replace Metal Frame	2003	7,572	505	15	505		1,010	54
55	Insulated Glass Units	2003	2,880	192	15	192		384	55
56	Ceiling Tile Replacement	2003	1,560	104	15	104		208	56
57	Chair Rail Installations	2003	750	75	10	75		150	57
58	Med Room Remodel	2003	3,400	170	20	170		340	58
59	Surge Protector	2003	2,348	157	15	157		314	59
60	Front enterance canopy	2003	1,054	70	15	70		140	60
61	Bedroom Furniture	2003	69,445	4,630	15	4,630		4,630	61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,603,979	$ 101,736		$ 101,736	$	$ 1,639,100	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,603,979	$ 101,736		$ 101,736	$	$ 1,639,100	1
2	Janitor Equip.	2003	554	111	5	111		394	2
3	Electric Food Processor	2003	689	69	10	69		353	3
4	Refinish Wood on 59	2003	2,100	300	7	300		1,596	4
5	Server	2003	2,377	475	5	475		148	5
6	Bi Fold Bedside Mat	2003	658	132	5	132		890	6
7	Light Bulbs	2003	667	133	5	133		896	7
8	Wheelchair with leg rest	2003	891	178	5	178		1,596	8
9	Phone Module	2003	630	90	7	90		2,516	9
10	Compressor A/C Unit	2003	1,104	74	15	74		220	10
11	Electric Comax Bed	2003	849	71	12	71		1,278	11
12	Bariatric Shower Chair	2003	664	66	10	66		128	12
13	Fence with Fence Master	2003	5,967	332	15	332		334	13
14	Down Spout	2003	10,650	976	10	976		84	14
15	5-ton rooftop	2003	6,737	562	10	562		3,292	15
16	Install outside electric lighting	2003	869	44	15	44		836	16
17	landscaping	2004	5,106	160	8	160		310	17
18									18
19	2004 Depreciation Adjustment			(618)			618		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
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4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
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4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	1
2									2
3									3
4									4
5									5
6									6
7									7
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,644,491	$ 104,891		$ 105,509	$ 618	$ 1,653,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 502,969	$ 25,042	$ 25,042	$	Various	$ 441,443	71
72	Current Year Purchases	16,365	924	924		Various	924	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 519,334	$ 25,966	$ 25,966	$		$ 442,367	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			97	$ 39,925	$	$	$	5	$ 39,925	76
77										77
78										78
79										79
80	TOTALS			$ 39,925	$	$	$		$ 39,925	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,214,750	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,857	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,475	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 618	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,136,263	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ X YES ☐ NO
16. Rental Amount for movable equipment: $ 2,033 Description: See attached detail for rental expense
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HILLSBORO HCC

STATE OF ILLINOIS
31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,191	$ 58,743	$ 0	1,191	$ 58,743	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		122	6,388	0	122	6,388	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		1,324	55,231	0	1,324	55,231	4
5	Physician Care	0	visits		0	0	0			5
6	Dental Care	0	visits		0	0	0			6
7	Work Related Program	0	hrs		0	0	0			7
8	Habilitation	0	hrs		0	0	0			8
9	Pharmacy		# of prescrpts		0	0	0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs		0	0	0			10
11	Academic Education	0	hrs		0	0	0			11
12	Exceptional Care Program	0			0	0	0			12
13	Other (specify):	0			0	0	0			13
14	TOTAL			$	2,637	$ 120,362	$	2,637	$ 120,362	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 485,015	$	1
2	Cash-Patient Deposits	19,297		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	192,454		3
4	Supply Inventory (priced at)	12,719		4
5	Short-Term Investments			5
6	Prepaid Insurance	(0)		6
7	Other Prepaid Expenses	12,295		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 721,780	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,000		13
14	Buildings, at Historical Cost	2,727,486		14
15	Leasehold Improvements, at Historical Cost	35,255		15
16	Equipment, at Historical Cost	600,630		16
17	Accumulated Depreciation (book methods)	(2,053,961)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	346,960		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(210,267)		20
21	Restricted Funds	1,957		21
22	Other Long-Term Assets (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,459,060	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,180,840	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,526	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,297		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,478		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,084		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,449,058		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	20,562		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,656,005	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,484,610		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,484,610	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,140,615	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,959,775)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,180,840	$	48

*(See instructions.)

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,541,254)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,541,257)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(418,517)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	0	15
16	Other (describe) **rounding**	(1)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (418,518)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,959,775)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,701,279	1
2	Discounts and Allowances for all Levels	(67,149)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,634,130	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,203	6
7	Oxygen	11,418	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 275,621	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,706	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	119,155	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,026	19
20	Radiology and X-Ray		20
21	Other Medical Services	48,312	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 218,199	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,806	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,806	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	10,962	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,962	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,144,718	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	630,133	31
32	Health Care	1,371,395	32
33	General Administration	852,646	33
	B. Capital Expense		
34	Ownership	506,498	34
	C. Ancillary Expense		
35	Special Cost Centers	136,134	35
36	Provider Participation Fee	66,429	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,563,235	40
41	**Income before Income Taxes (line 30 minus line 40)****	(418,517)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (418,517)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Pending If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,476	7,576	$ 216,092	$ 28.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,066	2,094	45,810	21.88	3
4	Licensed Practical Nurses	14,391	14,547	222,182	15.27	4
5	Nurse Aides & Orderlies	52,452	52,914	484,985	9.17	5
6	Nurse Aide Trainees	3,667	3,769	33,383	8.86	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,129	6,760	77,411	11.45	10
11	Social Service Workers	5,749	5,821	70,840	12.17	11
12	Dietician	15,958	16,133	145,976	9.05	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,808	1,888	23,078	12.22	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,008	2,171	66,525	30.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,192	4,248	59,929	14.11	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	840	888	10,103	11.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,736	118,809	$ 1,456,314 *	$ 12.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	98	$ 5,718	1, 3	35
36	Medical Director	245	12,240	9, 3	36
37	Medical Records Consultant	72	1,440	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	93	3,806	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	17	377	10a, 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	2,739	11, 3	44
45	Social Service Consultant	56	2,739	12, 3	45
46	Other(specify) 0				46
47					47
48					48
49	TOTAL (lines 35 - 48)	637	$ 29,058		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY BORROR	Admin.	0	$ 43,893
MARSHA JACOBS	Admin.	0	22,632
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,525

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type		Amount
Legal Fees	Various	0	$ 11,703
Purchased Service	Various		18,312
Data Processing	Various		7,606
Accounting	Various		8,825
Professional Services	Various		838
Management Fees	Various		188,335
Trustee Expense	Various		8,000
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed $2500 attach copy of invoices.)			$ 243,618

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,598
Unemployment Compensation Insurance	0
FICA Taxes	125,355
Employee Health Insurance	44,810
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Other Benefits	7,319
	0
	0
Home Office Allocation	6,765
TOTAL (agree to Schedule V, line 22, col.8)	$ 264,846

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	809
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	8,946
Advertising & Public Relations	22,485
0	
0	
Home Office Allocation	
Less: Public Relations Expense	
Non-allowable advertising	(22,485)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,756

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	888
Seminar Expense	0
Business Meals	
Home Office Allocation	3,491
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,379

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLSBORO HCC # 31674 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **6534 - Illinois Health Care Assoc.**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,145** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,429**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,706**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP KC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N** If no, please explain. **In progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.